# IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

**Work Group:** Clinical Quality Improvement
**Research Question:** Oregon Quality Metrics Summary

Sources: Oregon Health Authority, http://www.oregon.gov/oha/Metrics/Pages/index.aspx; Performance Data by Measures, http://www.oregon.gov/oha/Metrics/Pages/measures.aspx; Oregon Measurement Strategy, http://www.oregon.gov/oha/Documents/MeasurementStrategy.pdf

## 1. Background information

- The Oregon Health Authority (OHA) will publish quarterly reports showing performance data for each coordinated care organization (CCO) based on metrics established with stakeholder input through a legislatively mandated metrics and scoring committee.
- Based on 2011 baseline data gathered from CCO predecessor organizations, the quality measures will be used to track program goals, address disparities, and drive quality improvement through financial incentives, performance reporting, and rapid cycle feedback processes.

## 2. Performance measures and quality pool

- The State is tracking 18* incentive metrics in year one and 16 additional State performance metrics.
- Because financial incentives are a key strategy for stimulating quality of services and moving to value-based purchasing, OHA has developed a quality incentive pool comprised of a percentage of CCO payments made at-risk for performance and savings accrued from improved models of care to reward improvements in these metrics over the term of the demonstration.
- As local governance and provider involvement is one of the chief tenants of Oregon's CCO model, this structure creates the opportunity for incentive and performance-based contracting and alternative payment methodologies to allow gain sharing among CCOs and their providers.

**18 incentive measures for CCOs:**

| Focus Areas | Measures |
|---|---|
| Electronic health record adoption | Electronic health records adoption |
| Improving access to timely and effective care | Patient-centered primary care home enrollment |

* *Website reports that the state is tracking 17 CCO incentive measures. However, the actual number of measures is 18.*

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|---|---|
| Improving primary care for children | • Adolescent well-care visit<br>• Mental and physical health assessment within 60 days for children in DHS custody |
| Improving primary care for adults | • Colorectal cancer screening |
| Improving behavioral and physical health coordination | • Alcohol or other substance misuse (SBIRT)<br>• Follow-up after hospitalization for mental illness<br>• Follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication<br>• Screening for clinical depression and follow-up plan |
| Maternity and early childhood care | • Timeliness of prenatal care<br>• Developmental screening in the first 36 months of life<br>• PC-01: elective delivery |
| Patient experience | • CAHPS adult and child composites – satisfaction with care<br>• CAHPS adult and child composites – access to care |
| Reducing avoidable hospital admissions | • Diabetes, short term complication admission rate (PQI 01) |
| Reducing discrete health issues | • Controlling high blood pressure<br>• Diabetes: HbA1c poor control |
| Reducing preventable and unnecessarily costly utilization | • Ambulatory care: outpatient and emergency department utilization |

**16 additional state performance measures:**

| Focus Areas | Measures |
|---|---|
| Electronic health record adoption | None |
| Improving access to timely and effective care | • Child and adolescent access to primary care practitioners<br>• Provider access questions from the physician workforce survey |

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| Improving primary care for children | • Appropriate testing for children with pharyngitis<br>• Childhood immunization status<br>• Immunization for adolescents |
| Improving primary care for adults | • Cervical cancer screening<br>• Chlamydia screening in women ages 16-24<br>• Medical assistance with smoking and tobacco use cessation |
| Improving behavioral and physical health coordination | None |
| Maternity and early childhood care | • Prenatal and postpartum care: postpartum care rate<br>• Well-child visit in the first 15 months of life |
| Patient experience | None |
| Reducing avoidable hospital admissions | • Adult asthma admission rate (PQI 15)<br>• Chronic obstructive pulmonary disease or asthma admission (PQI 05)<br>• Congestive heart failure admission rate (PQI 18) |
| Reducing discrete health issues | • Comprehensive diabetes care: Hemoglobin A1c testing<br>• Comprehensive diabetes care: LDL-C screening |
| Reducing preventable and unnecessarily costly utilization | • Plan all-cause readmission |